RECEIPT

Circuit Court Clerk, Debbie Moss
Wilson County Circuit Civil Court
134 S. College St.
Lebanon, TN 37087
(615)444-2042

No: 216929
Receipt Date: 01/05/2016
System Date: 01/04/2016

Received Of: Sarah Katherine Rodgers

Total Amount Paid: $84.00

Payment Method/No: Cash $85.00

Amount Tendered: $85.00
Amount Returned: $1.00

Case: 95CC1-2015-CV-592
Linda Caldwell vs SSC Lebanon Operating Company LLC (et. al);

PAID IN FULL
Amount Paid: 84.00

Debbie Moss

By:
Mary Hamblen, mhamblen

Page 1 of 1

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By:
Mary Hamblen, mhamblen

Page 1 of 1

IN THE CIRCUIT COURT OF TENNESSEE FOR THE
FIFTEENTH JUDICIAL DISTRICT AT LEBANON, WILSON COUNTY

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased, and on behalf of the wrongful death beneficiaries of Sarah Katherine Rodgers

Plaintiff,

v.

Cause No. 2015-CV-592

Jury Demanded

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; SSC Submaster Holdings, LLC

Defendants.

I, DEBBIE MOSS, CLERK, DO HEREBY CERTIFY THE FOREGOING TO BE A TRUE AND CORRECT COPY OF THE ORIGINAL INSTRUMENT ON FILE IN THIS CASE.
JAN 04 2016
DEBBIE MOSS
CIRCUIT COURT CLERK
WILSON COUNTY, TN

FILED
2015 DEC -2 AM 11:15
CIRCUIT COURT CLERK
WILSON COUNTY, TN

COMPLAINT

COMES NOW Plaintiff, Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased against SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, Defendants, and for this cause of action would show as follows:

PARTIES

1. Linda Caldwell is the daughter of Sarah Katherine Rodgers and brings this action as Next of Kin of Sarah Katherine Rodgers, Deceased, and on behalf of the wrongful death beneficiaries of Sarah Katherine Rodgers.

2. Upon information and belief, Sarah Katherine Rodgers was a resident of Lebanon Health and Rehabilitation Center, a facility owned, operated and/or managed by Defendants located at 731 Castle Heights Court, Lebanon, Tennessee, from 2011 until on or

about October 20, 2014, when she was discharged to University Medical Center. Sarah Katherine Rodgers died on November 6, 2014 at the Pavilion in Lebanon, Tennessee.

3. At all times mentioned herein, Sarah Katherine Rodgers was unable to attend to her own affairs, was disabled, and incompetent within the meaning of Tenn. Code Ann. § 28-1-106.

4. The foregoing savings statute tolled the limitations period for Sarah Katherine Rodgers's claims against Lebanon Health and Rehabilitation Center and all of her claims are timely filed.

5. Nursing Home Defendant SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center is a Delaware limited liability company that at all times material to this action was the "licensee" authorized to operate a nursing facility under the name of Lebanon Health and Rehabilitation Center, Lebanon, Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center may be served with process through its registered agent, C T Corporation System, Suite 2021, 800 S Gay Street, Knoxville, TN 37929.

6. Nursing Home Defendant SMV Lebanon, LLC is a Delaware limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant SMV Lebanon, LLC may be served with process through its registered agent, VCorp Services, LLC, 15439 Old

Hickory Blvd., Nashville, TN 37211-6272.

7. Nursing Home Defendant Sava SeniorCare, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Sava SeniorCare, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.

8. Nursing Home Defendant Sava SeniorCare Administrative Services, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Sava SeniorCare Administrative Services, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.

9. Nursing Home Defendant Sava SeniorCare Consulting, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Sava SeniorCare Consulting, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE

19801.

10. Nursing Home Defendant Tennessee HoldCo, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Tennessee HoldCo, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.

11. Nursing Home Defendant SSC Submaster Holdings, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant SSC Submaster Holdings, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.

12. Whenever the term "Nursing Home Defendants" is utilized within this suit, such term collectively refers to and includes SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC.

13. Whenever in this suit it is alleged that Defendants did any act or thing or failed to do any act or things, it is meant that the officers, agents, or employees of the designated corporations respectively performed, participated in, or failed to perform such acts or

things while in the course and scope of their employment and/or agency relationship with said Defendants.

NATURE OF NURSING HOME DEFENDANTS' LIABILITY

14. **ALTER EGO:** Nursing Home Defendants, SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, were mere conduits through which Nursing Home Defendant, Sava SeniorCare, LLC, did business. The management and the operations of SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC were so assimilated within the parent, Sava SeniorCare, LLC, to the extent that the aforementioned subsidiaries were simply a name through which the parent, Sava SeniorCare, LLC, conducted its business. Moreover, Sava SeniorCare, LLC, represented to the public that its subsidiaries, SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, were part of one single economic enterprise known as Sava SeniorCare, LLC. Said parent corporation completely dominated and controlled the business affairs of its subsidiaries insomuch as SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, were organized and operated as mere tools of Sava SeniorCare, LLC.

17. **AGENCY:** In the alternative, at all times material to this suit, Nursing Home Defendants, SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC acted as agents of Nursing Home Defendant, Sava SeniorCare, LLC. As such, Nursing Home Defendant, Sava SeniorCare, LLC, ratified or authorized the acts or omissions of the other Nursing Home Defendants.

18. **JOINT ENTERPRISE:** In the alternative, to the extent that Nursing Home Defendants are found to be separate corporate entities and would not be liable for the acts of each other under theories that allow looking beyond the corporate fiction, each Corporate Defendant remains liable for the acts of the others because Nursing Home Defendants operated their business as a joint enterprise. Nursing Home Defendants engaged in a joint venture and acted in concert in the operation, management, and maintenance of Lebanon Health and Rehabilitation Center. These entities entered into an agreement with the common purpose of operating, managing, and maintaining Lebanon Health and Rehabilitation Center. These entities had an equal right to control their venture as a whole, as well as to control the operation and management of the subject facility.

FACTS

19. Upon information and belief, Sarah Katherine Rodgers was a resident at Lebanon Health and Rehabilitation Center, a skilled nursing facility located at 731 Castle Heights Court, Lebanon, Tennessee, from 2011 until on or about October 20, 2014, when she was discharged to University Medical Center. Sarah Katherine Rodgers died on November 8, 2014 at the Pavilion in Lebanon, Tennessee.

20. At all times mentioned hereto, Sarah Katherine Rodgers was of unsound mind and unable to attend to her affairs or care for herself throughout her residency at Lebanon Health and Rehabilitation Center.

21. While in the care of Nursing Home Defendants, Sarah Katherine Rodgers suffered injuries and harm which include, but are not limited to, the following:

- Development and worsening of wounds to the sacrum/ coccyx/ buttocks;
- Infections, including UTIs, and proteus mirabilis;
- Malnutrition;
- Poor hygiene;
- Severe pain; and
- Untimely Death

22. As a result of these injuries, Sarah Katherine Rodgers required medical attention and her overall health deteriorated, causing unnecessary physical suffering and mental anguish, and her death.

23. The injuries described in this Complaint are a direct and proximate result of the acts or omissions set forth herein, singularly or in combination.

VENUE

24. The injuries made the basis of this lawsuit were products of the corporate and financial policies designed, formulated, and implemented by Nursing Home Defendants at Lebanon Health and Rehabilitation Center. Venue for this action lies in Wilson County, Tennessee.

CAUSES OF ACTION AGAINST NURSING HOME DEFENDANTS

NEGLIGENCE PURSUANT TO THE TENNESSEE HEALTH CARE LIABILITY ACT, TENN. CODE ANN. §§ 29-26-101, ET SEQ.

25. Plaintiff brings a claim for violation of T.C.A. §§ 29-26-101, et seq., as amended October 1, 2011. Plaintiff contends, however, that T.C.A. § 29-26-101 is unconstitutional, as amended, under the Constitutions of the State of Tennessee and the United States and violates due process, the separation of powers doctrine, and the inherent authority of the courts to protect the integrity of the proceedings and the rights of the litigants. The assertion of a cause of action under this statute should not be deemed a waiver of Plaintiff's right to challenge the constitutionality of the statute.

26. Plaintiff re-alleges and incorporates all prior allegations in paragraphs 1-24 as if fully set forth herein.

27. Plaintiff has complied with Tenn. Code Ann. § 29-26-121(a) by providing notice of the claim by certified mail to all Defendants at both the address listed for each defendant on the Tennessee Department of Health website and at the defendant's current business address, all of which is evidenced by the Affidavit(s) of M. Chad Trammell attached as Exhibit "A" and incorporated by reference, verifying notice was sent by certified mail to Defendants on August 18, 2015. A copy of each notice and each Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing, are attached to the Affidavit(s) and establish that the specified notices were timely mailed by certified mail, return receipt requested. The requirements of T.C.A. § 29-26-121(a) have been satisfied.

28. Plaintiff complied timely with the notice requirements of T.C.A. § 29-26-121(a) by giving notice and providing the documents required by T.C.A. § 29-26-121(a) to all Defendants more than 60 days before the filing of this Complaint.

29. Plaintiff has complied with Tenn. Code Ann. § 29-26-122 by filing the required Certificate of Good Faith with this Complaint, attached as Exhibit "B" and incorporated by reference.

30. Nursing Home Defendants are "health care providers" within the meaning of T.C.A. § 29-26-101 and owed a duty to Sarah Katherine Rodgers to provide her healthcare services in a safe and beneficial manner.

31. Nursing Home Defendants breached their duties owed to Sarah Katherine Rodgers, thereby causing Sarah Katherine Rodgers to be injured as set forth in this Complaint. Such breaches by Nursing Home Defendants include, but are not limited to, the following:

(a) Failure to provide sufficient numbers of certified nursing assistants to meet the custodial needs of Sarah Katherine Rodgers, including, but not limited to, food, water, baths, showers, grooming, incontinent care, personal attention and care to her skin, feet, and nails, oral hygiene, and haircuts;

(b) Failure to administer the facility in such a manner so as to provide the facility with adequate resources to ensure sufficient non-medical (CNA) staffing and supplies, such as diapers, linens, and towels, to care for all residents, including Sarah Katherine Rodgers;

(c) Failure to provide sufficient number of non-licensed staff to follow Sarah Katherine Rodgers' care plans and to prevent Sarah Katherine Rodgers' needs from being ignored;

(d) Failure to provide adequate supervision and oversight to non-licensed personnel to ensure that Sarah Katherine Rodgers received adequate and proper custodial care;

(e) Failure to provide adequate overall custodial (non-medical) care;

(f) Failure to provide adequate and appropriately trained non-licensed staff and supervision to such personnel so as to ensure that Sarah Katherine Rodgers received adequate and proper custodial care, adequate hydration, and warm and palatable meals;

(g) Failure to adopt adequate guidelines, policies and procedures for documenting, maintaining files, investigating and responding to any complaint regarding the quantity of resident care, the quality of resident care, or misconduct by Nursing Home Defendants' employees, irrespective of whether such complaint derived from a state or federal survey agency, resident of said facility, an employee of said facility or any interested person (with regard to non-medical complaints);

(h) Failure by the members of the governing body of the nursing home to discharge their legal and lawful obligation by:

(1) ensuring that the rules and regulations designed to protect the health and safety of the patients, such as Sarah Katherine Rodgers as promulgated by the Tennessee Legislature and corresponding regulations implemented expressly pursuant thereto by the Tennessee Department of Health and its agents, including the Division of Health Care Facilities, were consistently complied with on an ongoing basis;

(2) ensuring that the resident care policies for the facility were consistently in compliance on an ongoing basis; and

(3) responsibly ensuring that appropriate corrective measures were implemented to correct problems concerning inadequate resident care (non-medical).

(i) Failure of non-licensed personnel to maintain records in accordance with accepted standards and practices that are complete, accurately documented, readily accessible, and systematically organized with respect to Sarah Katherine Rodgers;

(j) Failure to provide basic and necessary non-medical care and supervision during Sarah Katherine Rodgers' residency;

(k) Failure to protect Sarah Katherine Rodgers from abuse and neglect during her residency;

(l) Failure to treat Sarah Katherine Rodgers with kindness and respect;

(m) Failure of high managerial agents and corporate officers to adequately hire, train, supervise, and retain the administrator and other staff so as to assure that Sarah Katherine Rodgers received care in accordance with Nursing Home Defendants' policies and procedures;

(n) Making false, misleading, and deceptive representations as to the quality of care, treatment and services provided by the facility to their residents, including Sarah Katherine Rodgers;

(o) Failure to provide and ensure adequate nursing care plans, including necessary revisions, based on the needs of Sarah Katherine Rodgers;

(p) Failure to develop and implement an adequate nursing care plan for Sarah Katherine Rodgers that was followed by nursing personnel;

(q) Failure to take reasonable steps to prevent, eliminate, and correct medical deficiencies and problems in resident care;

(r) Failure to provide care, treatment, and medication to Sarah Katherine Rodgers in accordance with physician's orders;

(s) Failure to properly and timely notify Sarah Katherine Rodgers' attending physician and/or nurse practitioners of significant changes in her physical condition;

(t) Failure to adequately assess, monitor, and address Sarah Katherine Rodgers' nutritional status in order to prevent weight loss;

(u) Failure to provide a safe environment for Sarah Katherine Rodgers;

(v) Failure to properly assess Sarah Katherine Rodgers in order to prevent infections;

(w) Failure to adequately and appropriately monitor Sarah Katherine Rodgers and recognize significant changes in her health status;

(x) Failure to adequately assess, monitor and treat Sarah Katherine Rodgers in order to prevent the development and worsening of pressure sores; and

(y) Failure to provide treatment for persistent, unresolved problems related to the care and physical condition of Sarah Katherine Rodgers, resulting in her unnecessary pain, agony, and suffering.

32. Nursing Home Defendants' conduct in breaching the duties they owed Sarah Katherine Rodgers was negligent, grossly negligent, willful, wanton, malicious, reckless, and/or intentional.

33. As a direct and proximate result of such negligent, grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Sarah Katherine Rodgers was injured, for which Plaintiff asserts a claim for judgment for all compensatory and punitive damages against Nursing Home Defendants, including, but not limited to medical expenses, pain and suffering, mental anguish, disability, and humiliation in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

SURVIVAL AND WRONGFUL DEATH CLAIM

34. Plaintiff re-alleges and incorporates the allegations in paragraphs 1-33 as if fully set forth herein.

35. As a direct and proximate result of the acts or omissions of Defendants as set forth above, Sarah Katherine Rodgers suffered mental anguish, pain and suffering, and physical injuries which include, but are not limited to, those described herein, including death.

36. As a further direct and proximate result of Defendants' conduct, Sarah Katherine Rodgers required medical attention and hospitalization, and incurred liability to pay reasonable and necessary charges for such.

37. As a direct, natural and proximate result of the acts or omissions of Defendants as set forth above, Sarah Katherine Rodgers died on November 6, 2014, thereby incurring reasonable and necessary charges for funeral and related expenses.

38. As a direct and proximate result of the previously alleged conduct, all of which was negligent, grossly negligent, willful and wanton, outrageous, reckless, malicious, and/or intentional, Sarah Katherine Rodgers endured pain, suffering, and death. Indeed, Sarah Katherine Rodgers suffered personal injury including excruciating pain and suffering, mental anguish, emotional distress, and humiliation, which includes, but is not limited to, that described herein. Additionally, Sarah Katherine Rodgers's family has suffered more than the normal grief on losing the life of their loved one and accordingly seeks damages for loss of attention, guidance, care, protection, companionship, cooperation, affection, and love. Accordingly, Plaintiff is entitled to recover against Defendants compensatory and punitive damages based on the foregoing.

DAMAGES

39. Plaintiff re-alleges and incorporates the allegations in paragraphs 1-38 as if fully set forth herein.

40. As a direct and proximate result of the acts and omissions of all Nursing Home Defendants as set out above, Sarah Katherine Rodgers suffered injuries including, but not limited to, those described herein. As a result, Sarah Katherine Rodgers incurred significant medical expenses and suffered embarrassment and physical impairment and pain and suffering.

41. Plaintiff seeks punitive and compensatory damages against Nursing Home Defendants in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

42. To the extent T.C.A. §§ 29-39-101, et seq., is asserted by Nursing Home Defendants or deemed applicable to the present case or controversy, Plaintiff affirmatively avers that these statutory provisions are unconstitutional.

The Constitution of the State of Tennessee provides for:

(1) Right to Trial by Jury.

[T]he right of trial by jury shall remain inviolate ....

Tennessee Constitution, Art. 1, Sec. 6.

(2) Open Courts.

[A]ll courts shall be open; and every man, for an injury done him in his lands, goods, person or reputation, shall have remedy by due course of law, and right and justice administered without sale, denial, or delay.

Tennessee Constitution, Art. 1, Sec. 17.

(3) Separation of Powers.

The powers of the government shall be divided into three distinct departments: legislative, executive and judicial.

Tennessee Constitution, Art. 2, Sec. 1.

No person or persons belonging to one of these departments shall exercise any of the powers properly belonging to either of the others, except in the cases herein directed or permitted.

Tennessee Constitution, Art. 2, Sec. 2.

The Constitution of the United States provides for:

(1) Right to Trial by Jury.

In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

United States Constitution, Amendment VII.

(2) Due Process and Equal Protection.

...No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; ...without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws ...

United States Constitution, Amendment XIV.

43. Plaintiff asserts that Tenn. Code Ann. §§ 29-39-101, et seq., violates the Constitutions of the State of Tennessee and the United States by affecting the right to trial by jury, open courts, separation of powers, equal protection, and due process.

REQUEST FOR TRIAL BY JURY

44. Plaintiff demands a trial by jury of twelve (12) on all issues herein set forth.

PRAYER FOR RELIEF

45. Pursuant to Tennessee Rules of Civil Procedure, Plaintiff demands that all issues of fact in this case be tried by a jury.

RELIEF SOUGHT

WHEREFORE, Plaintiff prays for judgment against Defendants, as follows:

1) For damages to be determined by the jury, in an amount to compensate adequately Plaintiff for all the injuries and damages sustained;

2) For all general and special damages caused by the alleged conduct of Defendants;

3) For the costs of litigating this case;

4) For punitive damages sufficient to punish Defendants for their egregious conduct and to deter Defendants and others from repeating such atrocities; and

5) For all other relief to which Plaintiffs are entitled by Tennessee law, including attorneys' fees, as specifically provided for by T.C.A. § 71-6-101, *et seq.* and T.C.A. § 47-14-101, *et seq.*

WHEREFORE, Plaintiff respectfully reserves her right to amend this Complaint to conform to the evidence as it develops.

Respectfully Submitted,

TRAMMELL PIAZZA LAW FIRM, PLLC

M. Chad Trammell

TN BPR# 021146
418 North State Line Avenue
Texarkana, Arkansas 71854
Telephone: 870.779.1860
Facsimile: 870.779.1861

And

Daniel L. Clayton, BPR #12600
KINNARD, CLAYTON & BEVERIDGE
127 Woodmont Boulevard
Nashville, Tennessee 37205
(615) 297-1007
(615) 297-1505 FAX

Attorneys for Plaintiff

Ready to serve

Wilson County	**STATE OF TENNESSEE** **CIVIL SUMMONS** page 1 of 1	**Case Number** 2015-CV-590

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

Served On: SSC Submaster Holdings, LLC c/o The Corporation Trust Company, Corporation Trust Center

1209 Orange St., Wilmington, DE 19801

You are hereby summoned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made within thirty (30) days from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a copy to the plaintiff's attorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered against you for the relief sought in the complaint.

Issued: December 2, 2015 Meagan Swink DC
Clerk / Deputy Clerk

Attorney for Plaintiff: M. Chad Trammell
418 North State Line, Texarkana, AR 71854

NOTICE OF PERSONAL PROPERTY EXEMPTION

TO THE DEFENDANT(S): Tennessee law provides a ten thousand dollar ($10,000) personal property exemption as well as a homestead exemption from execution or seizure to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are listed in TCA § 26-2-301. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer. Please state file number on list.

Mail list to _____, _____ Clerk, _____ County

CERTIFICATION (IF APPLICABLE)

I, _____, _____ Clerk of _____ County do certify this to be a true and correct copy of the original summons issued in this case.

Date: _____ _____
Clerk / Deputy Clerk

OFFICER'S RETURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law.

I certify that I have served this summons together with the complaint as follows: _____

Date: _____ By: _____
Officer, Title

RETURN ON SERVICE OF SUMMONS BY MAIL: I hereby certify and return that on _____, I sent postage prepaid, by registered return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above styled case, to the defendant _____. On _____ I received the return receipt, which had been signed by _____ on _____. The return receipt is attached to this original summons to be filed by the Court Clerk.

Date: _____ _____
Notary Public / Deputy Clerk (Comm. Expires _____)

_____ _____
Signature of Plaintiff Plaintiff's Attorney (or Person Authorized to Serve Process)

(Attach return receipt on back)

ADA: If you need assistance or accommodations because of a disability, please call _____, ADA Coordinator, at ( ) _____.

Wilson County	**STATE OF TENNESSEE** **CIVIL SUMMONS** page 1 of 1	**Case Number** 2015-CV-502

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

Served On: Tennessee HoldCo, LLC c/o The Corporation Trust Company, Corporation Trust Center

1209 Orange St., Wilmington, DE 19801

You are hereby summoned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made within thirty (30) days from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a copy to the plaintiff's attorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered against you for the relief sought in the complaint.

Issued: December 2, 2015 Allgan Swink (D)
Clerk / Deputy Clerk

Attorney for Plaintiff: M. Chad Trammell
418 North State Line, Texarkana, AR 71854

NOTICE OF PERSONAL PROPERTY EXEMPTION

TO THE DEFENDANT(S): Tennessee law provides a ten thousand dollar ($10,000) personal property exemption as well as a homestead exemption from execution or seizure to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are listed in TCA § 26-2-301. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer. Please state file number on list.

Mail list to _____, _____ Clerk, _____ County

CERTIFICATION (IF APPLICABLE)

I, _____, _____ Clerk of _____ County do certify this to be a true and correct copy of the original summons issued in this case.

Date: _____ _____
Clerk / Deputy Clerk

OFFICER'S RETURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law.

I certify that I have served this summons together with the complaint as follows: _____

Date: _____ By: _____
Officer, Title

RETURN ON SERVICE OF SUMMONS BY MAIL: I hereby certify and return that on _____, I sent postage prepaid, by registered return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above styled case, to the defendant _____. On _____ I received the return receipt, which had been signed by _____ on _____. The return receipt is attached to this original summons to be filed by the Court Clerk.

Date: _____ _____
Notary Public / Deputy Clerk (Comm. Expires _____)

_____ _____
Signature of Plaintiff Plaintiff's Attorney (or Person Authorized to Serve Process)

(Attach return receipt on back)

ADA: If you need assistance or accommodations because of a disability, please call _____, ADA Coordinator, at ( ) _____.

 Rev. 03/11

Wilson County	**STATE OF TENNESSEE** **CIVIL SUMMONS** page 1 of 1	**Case Number** 2015-CV-592

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

Served On: Sava SeniorCare Consulting, LLC c/o The Corporation Trust Company, Corporation Trust Center

1209 Orange St., Wilmington, DE 19801

You are hereby summoned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made within thirty (30) days from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a copy to the plaintiff's attorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered against you for the relief sought in the complaint.

Issued: December 2, 2015 Megan Brinkley
Clerk / Deputy Clerk

Attorney for Plaintiff: M. Chad Trammell
418 North State Line, Texarkana, AR 71854

NOTICE OF PERSONAL PROPERTY EXEMPTION

TO THE DEFENDANT(S): Tennessee law provides a ten thousand dollar ($10,000) personal property exemption as well as a homestead exemption from execution or seizure to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are listed in TCA § 26-2-301. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer. Please state file number on list.

Mail list to _____, _____ Clerk, _____ County

CERTIFICATION (IF APPLICABLE)

I, _____, _____ Clerk of _____ County do certify this to be a true and correct copy of the original summons issued in this case.

Date: _____ _____
Clerk / Deputy Clerk

OFFICER'S RETURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law.

I certify that I have served this summons together with the complaint as follows: _____

Date: _____ By: _____
Officer, Title

RETURN ON SERVICE OF SUMMONS BY MAIL: I hereby certify and return that on _____, I sent postage prepaid, by registered return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above styled case, to the defendant _____. On _____ I received the return receipt, which had been signed by _____ on _____. The return receipt is attached to this original summons to be filed by the Court Clerk.

Date: _____ _____
Notary Public / Deputy Clerk (Comm. Expires _____)

_____ _____
Signature of Plaintiff Plaintiff's Attorney (or Person Authorized to Serve Process)

(Attach return receipt on back)

ADA: If you need assistance or accommodations because of a disability, please call _____, ADA Coordinator, at ( ) _____.

(Attny to serve

Wilson County	**STATE OF TENNESSEE** **CIVIL SUMMONS** page 1 of 1	Case Number 2015-CV-592

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

Served On: Sava SeniorCare Administrative Services, LLC c/o The Corporation Trust Company, Corporation

Trust Center, 1209 Orange St., Wilmington, DE 19801

You are hereby summoned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made within thirty (30) days from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a copy to the plaintiff's attorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered against you for the relief sought in the complaint.

Issued: December 2, 2015 Megan Smith (DC)
Clerk / Deputy Clerk

Attorney for Plaintiff: M. Chad Trammell
418 North State Line, Texarkana, AR 71854

NOTICE OF PERSONAL PROPERTY EXEMPTION

TO THE DEFENDANT(S): Tennessee law provides a ten thousand dollar ($10,000) personal property exemption as well as a homestead exemption from execution or seizure to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are listed in TCA § 26-2-301. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer. Please state file number on list.

Mail list to _____, _____ Clerk, _____ County

CERTIFICATION (IF APPLICABLE)

I, _____, _____ Clerk of _____ County do certify this to be a true and correct copy of the original summons issued in this case.

Date: _____ _____
Clerk / Deputy Clerk

OFFICER'S RETURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law.

I certify that I have served this summons together with the complaint as follows: _____

_____

Date: _____ By: _____
Officer, Title

RETURN ON SERVICE OF SUMMONS BY MAIL: I hereby certify and return that on _____, I sent postage prepaid, by registered return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above styled case, to the defendant _____. On _____ I received the return receipt, which had been signed by _____ on _____. The return receipt is attached to this original summons to be filed by the Court Clerk.

Date: _____ _____
Notary Public / Deputy Clerk (Comm. Expires _____)

_____ _____
Signature of Plaintiff Plaintiff's Attorney (or Person Authorized to Serve Process)

(Attach return receipt on back)

ADA: If you need assistance or accommodations because of a disability, please call _____, ADA Coordinator, at ( ) _____.

Wilson County	**STATE OF TENNESSEE** **CIVIL SUMMONS** page 1 of 1	Case Number 2015-CV-592

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

Served On: Sava SeniorCare, LLC c/o The Corporation Trust Company, Corporation Trust Center

1209 Orange St., Wilmington, DE 19801

You are hereby summoned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made within thirty (30) days from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a copy to the plaintiff's attorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered against you for the relief sought in the complaint.

Issued: December 2, 2015 Megan Swink (DC)
Clerk / ~~Deputy~~ Clerk

Attorney for Plaintiff: M. Chad Trammell
418 North State Line, Texarkana, AR 71854

NOTICE OF PERSONAL PROPERTY EXEMPTION

TO THE DEFENDANT(S): Tennessee law provides a ten thousand dollar ($10,000) personal property exemption as well as a homestead exemption from execution or seizure to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are listed in TCA § 26-2-301. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer. Please state file number on list.

Mail list to _____, _____ Clerk, _____ County

CERTIFICATION (IF APPLICABLE)

I, _____, _____ Clerk of _____ County do certify this to be a true and correct copy of the original summons issued in this case.

Date: _____ _____
Clerk / Deputy Clerk

OFFICER'S RETURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law.

I certify that I have served this summons together with the complaint as follows: _____

_____

Date: _____ By: _____
Officer, Title

RETURN ON SERVICE OF SUMMONS BY MAIL: I hereby certify and return that on _____, I sent postage prepaid, by registered return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above styled case, to the defendant _____. On _____ I received the return receipt, which had been signed by _____ on _____. The return receipt is attached to this original summons to be filed by the Court Clerk.

Date: _____ _____
Notary Public / Deputy Clerk (Comm. Expires _____)

_____ _____
Signature of Plaintiff Plaintiff's Attorney (or Person Authorized to Serve Process)

(Attach return receipt on back)

ADA: If you need assistance or accommodations because of a disability, please call _____, ADA Coordinator, at ( ) _____.

Wilson County	**STATE OF TENNESSEE** **CIVIL SUMMONS** page 1 of 1	Case Number 2015-CV-592

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

Served On: SMV Lebanon, LLC c/o VCorp Services, LLC

15439 Old Hickory Blvd., Nashville, TN 37211-6272

You are hereby summoned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made within thirty (30) days from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a copy to the plaintiff's attorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered against you for the relief sought in the complaint.

Issued: December 2, 2015 Megan Swink (DC)
Clerk / Deputy Clerk

Attorney for Plaintiff: M. Chad Trammell
418 North State Line, Texarkana, AR 71854

NOTICE OF PERSONAL PROPERTY EXEMPTION

TO THE DEFENDANT(S): Tennessee law provides a ten thousand dollar ($10,000) personal property exemption as well as a homestead exemption from execution or seizure to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are listed in TCA § 26-2-301. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer. Please state file number on list.

Mail list to _____, _____ Clerk, _____ County

CERTIFICATION (IF APPLICABLE)

I, _____, _____ Clerk of _____ County do certify this to be a true and correct copy of the original summons issued in this case.

Date: _____ _____
Clerk / Deputy Clerk

OFFICER'S RETURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law.

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Date: _____ By: _____
Officer, Title

RETURN ON SERVICE OF SUMMONS BY MAIL: I hereby certify and return that on _____, I sent postage prepaid, by registered return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above styled case, to the defendant _____. On _____ I received the return receipt, which had been signed by _____ on _____. The return receipt is attached to this original summons to be filed by the Court Clerk.

Date: _____ _____
Notary Public / Deputy Clerk (Comm. Expires _____)

_____ _____
Signature of Plaintiff Plaintiff's Attorney (or Person Authorized to Serve Process)

(Attach return receipt on back)

ADA: If you need assistance or accommodations because of a disability, please call _____, ADA Coordinator, at ( ) _____.

Wilson County	**STATE OF TENNESSEE** **CIVIL SUMMONS** page 1 of 1	Case Number 2015-CV-392

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

Served On:

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o

CT Corporation, Suite 2021, 800 Gay St., Knoxville, TN 37929-9710

You are hereby summoned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made within thirty (30) days from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a copy to the plaintiff's attorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered against you for the relief sought in the complaint.

Issued: December 2, 2015

Megan Swink DC
Clerk / Deputy Clerk

Attorney for Plaintiff: M. Chad Trammell
418 North State Line, Texarkana, AR 71854

NOTICE OF PERSONAL PROPERTY EXEMPTION

TO THE DEFENDANT(S): Tennessee law provides a ten thousand dollar ($10,000) personal property exemption as well as a homestead exemption from execution or seizure to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are listed in TCA § 26-2-301. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer. Please state file number on list.

Mail list to _____, _____ Clerk, _____ County

CERTIFICATION (IF APPLICABLE)

I, _____, _____ Clerk of _____ County do certify this to be a true and correct copy of the original summons issued in this case.

Date: _____

_____
Clerk / Deputy Clerk

OFFICER'S RETURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law.

I certify that I have served this summons together with the complaint as follows: _____

_____

Date: _____

By: _____
Officer, Title

RETURN ON SERVICE OF SUMMONS BY MAIL: I hereby certify and return that on _____, I sent postage prepaid, by registered return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above styled case, to the defendant _____. On _____ I received the return receipt, which had been signed by _____ on _____. The return receipt is attached to this original summons to be filed by the Court Clerk.

Date: _____

_____
Notary Public / Deputy Clerk (Comm. Expires _____)

_____
Signature of Plaintiff

_____
Plaintiff's Attorney (or Person Authorized to Serve Process)

(Attach return receipt on back)

ADA: If you need assistance or accommodations because of a disability, please call _____, ADA Coordinator, at ( ) _____.

EXHIBIT

"A"

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center, 731 Castle Heights Court Lebanon, TN 37087, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA
LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Linda Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**
Linda Caldwell	Daughter

Revised 3/2003

EXHIBIT 3 tabbies

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. AC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Linda Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**
Linda Caldwell	Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center
Provider's/Health Plan's Address:	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MC (Initial) If not applicable, check here. ☐

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5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**
Linda Caldwell	Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From:
Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:
SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Ce
731 Castle Heights Court
Lebanon, TN 37087

PS Form 3817, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Jan Presley ☑ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 8-21

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☑ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 1960

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1960

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

LEBANON, TN 37087

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage	$6.25

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

08/18/2015

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center, 1 Ravinia Drive Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Lebanon Operating Company, LLC to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ___ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing
This form may be used for domestic and international mail

From:

~~Trammell Piazza Law Firm, PLLC~~
~~418 North State Line Ave.~~
~~Texarkana, AR 71854~~

To: SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Ce
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X H. Holley ☐ Agent ☐ Addressee

B. Received by (Printed Name) H. Holley C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 1953

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1953

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

ATLANTA, GA 30346

Postage	$3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
	$0.00

0504
07

$6.25

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

08/18/2015

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center, c/o C T Corporation System, Suite 2021, 800 Gay Street Knoxville, TN 37929, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Lebanon Operating Company, LLC to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

TRAMMELL PIAZZA LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

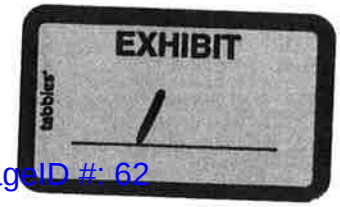
(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure



Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films and studies ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3 (tabbies)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Caldwell	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Linda Caldwell	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To: SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Ce
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

PS Form 3817, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18, 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Chucka Milligan ☐ Agent ☐ Addressee

B. Received by (Printed Name) AUG 21 2015 C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

☐ Yes

2. Artic
(Trans.

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1946

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

KNOXVILLE, TN 37929

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (E	$0.00 $0.00
	$0.71

0504 07 AUG 18 2015 Postmark Here

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SMV Lebanon, LLC c/o VCORP Services to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

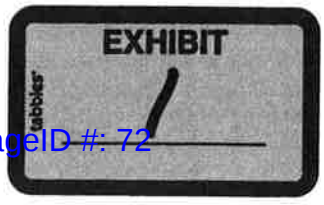
(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure



Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SMV Lebanon, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	**Relationship to Patient/Plan Member:** Daughter

Revised 3/2003

EXHIBIT tabbies 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	Social Security No. *(optional)*:
Sarah Katherine Rodgers	5-15-26	415-30-9090
Provider's/Health Plan's Name:	Recipient's Name: SMV Lebanon, LLC	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City: / State: / Zip:	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. AC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
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3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
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5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Linda Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SMV Lebanon, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MC (Initial) If not applicable, check here. ☐

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2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
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6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To: SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
$1.35
R2305E125034-07

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery
08/21/15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 1984

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1984

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE
NEW YORK, NY 10006

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00 $0.00
Total Postage & Fees	$6.96

0504
07
Postmark Here

Sent To SMV Lebanon, LLC 08/18/2015
Street, Apt. No.; or PO Box No. 45 Broadway, Suite 520
City, State, ZIP+4 New York, NY 10006

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT
5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SMV Lebanon, LLC c/o VCORP Services, LLC, 15439 Old Hickory Blvd Nashville, TN 37211, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SMV Lebanon, to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

EXHIBIT 1

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

EXHIBIT 2

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SMV Lebanon, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Linda Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	**Relationship to Patient/Plan Member:** Daughter

Revised 3/2003

EXHIBIT 3 tabbies

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	Social Security No. *(optional)*:
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SMV Lebanon, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/31/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

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Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	Social Security No. *(optional)*:
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SMV Lebanon, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

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2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
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5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From:
Trammell Piazza Law Firm, PLL(
418 North State Line Ave.
Texarkana, AR 71854

To:
SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

PS Form 3817, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4
tabbies

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) SHAUN STALLINGS

C. Date of Delivery 8/26/15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☒ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 1977

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1977

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

NASHVILLE, TN 37211

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00 $0.00
Total Postage	$0.71

AUG 28 2015 Postmark Here

Sent To SMV Lebanon, LLC
Street, Apt. No. or PO Box No. c/o VCORP Services, LLC
City, State, ZIP 15439 Old Hickory Blvd
Nashville, TN 37211

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA 30060, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare, LLC c/o The Corporation Company to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November 2015.

NOTARY PUBLIC

My commission expires: 3-28-22

TRAMMELL PIAZZA
LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

EXHIBIT 2

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
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6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/31/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

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☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. SRC (Initial) If not applicable, check here. ☐

I understand that:
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If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

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☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ____ (Initial) If not applicable, check here. ☐

I understand that:
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Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From:
Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:
SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [signature] C. Date of Delivery 8-21-15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

[signature]

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 1991

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1991

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE
MARIETTA, GA 30060

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00 $0.00
Total Postage & Fees	$0.71 $

0504 07
TEXARKANA, AR 71854
Postmark Here
AUG 18 2015

Sent To SavaSeniorCare, LLC
Street, Apt. or PO Box c/o The Corporation Company
328 Alexander Street, Suite 10
City, State Marietta, GA, 30060

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT
tabbies
5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting Tennessee HoldCo, LLC to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

/s/ Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA
LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

EXHIBIT
2

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: Tennessee HoldCo, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3 tabbies

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: Tennessee HoldCo, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

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Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090
Provider's/Health Plan's Name:	Recipient's Name: Tennessee HoldCo, LLC	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City: / State: / Zip:	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

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Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:
- Tennessee HoldCo, LLC
- One Ravinia Drive, Suite 1500
- Atlanta, GA 30346

PS Form 3817, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta GA 30346

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) A. Holley | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 1922

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1922

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE
ATLANTA, GA 30346

Postage	$3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.25

0504 07 1054
Postmark Here
AUG 18 2015

Sent To Tennessee HoldCo, LLC
Street, Apt. or PO Box One Ravinia Drive, Suite 1500
City, State, Atlanta, GA 30346

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Submaster Holdings, LLC to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES, March 28, 2022
Miller County

TRAMMELL PIAZZA
LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

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d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
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Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

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One Ravinia Drive, Suite 1500
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328 Alexander Street, Suite 10
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Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Submaster Holdings, LLC	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SSC Submaster Holdings, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

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Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Linda Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**
Linda Caldwell	Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090
Provider's/Health Plan's Name:	Recipient's Name: SSC Submaster Holdings, LLC	
Provider's/Health Plan's Address:	Address 1:	
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This authorization will expire on the following: (Fill in the Date or the Event but not both.)
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Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

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Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

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Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

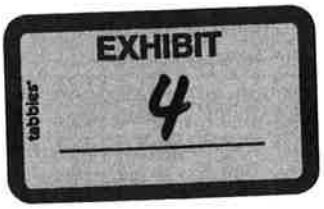
From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18, 15
AMOUNT
$1.35
R2305E125034-07



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) A Holley C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 1939

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 1939

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

ATLANTA, GA 30346

Postage	$3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00 $0.00
Total Postage & Fees	$6.96

0504
07
Postmark Here

09/18/2015

Sent To SSC Submaster Holdings, LLC
Street, or PO Box One Ravinia Drive, Suite 1500
City, St Atlanta, GA 30346

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Consulting, LLC c/o the Corpration Company 328 Alexander Street, Suite 10 Marietta, GA 30060, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Consulting, LLC c/o the Corpration Company to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA
LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Consulting, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LMC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Consulting, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Linda Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**
Linda Caldwell	Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Consulting, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
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5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE

Certificate Of Mailin

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailin
This form may be used for domestic and international mail

From:
Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:
SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18, 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 8-28-15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

[signature]

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 2011

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 2011

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

MARIETTA, GA 30060

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00 $0.00
Total Postage & Fees	$6.25

0504
07
Postmark Here

08/18/2015

Sent To SavaSeniorCare Consulting, LLC
Street, Apt. or PO Box c/o The Corporation Company
328 Alexander Street, Suite 10
City, State Marietta, GA, 30060

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Consulting, LLC to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA
LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
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Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
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Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Consulting, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Consulting, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Caldwell	7-31-15
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**
Linda Caldwell	Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Consulting, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JAC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS for mailing. This form may be used for domestic and international mail.

From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:
SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18, 15
AMOUNT
$1.35
R2305E125034-07

000

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) A. Holley | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 2004

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 2004

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®
OFFICIAL USE
ATLANTA, GA 30346

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00 $0.00
Total Postage & Fees	$0.71 $ $6.96

0504 07
Postmark Here
08/18/2015

Sent To SavaSeniorCare Consulting, LLC
Street, Apt. or PO Box One Ravinia Drive, Suite 1500
City, State, Atlanta, GA 30346

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Administrative Services, LLC to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12336943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Consulting, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Administrative Services, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Administrative Services, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
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5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	Social Security No. *(optional)*:
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Administrative Services, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
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5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Caldwell	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

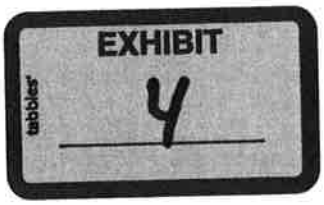
This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:
- SavaSeniorCare Administrative Services,
. One Ravinia Drive, Suite 1500
Atlanta, GA 30346

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18, 15
AMOUNT
$1.35
R2305E125034-07



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) A. Holley C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 2035

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 2035

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

ATLANTA, GA 30346

Postage	$3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.25

0504
07

Postmark Here

AUG 18 2015

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

Sent To
St. or P.O.
City, S.

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA 30060, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Administrative Services, LLC c/o The Corporation Company to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12396943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA
LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

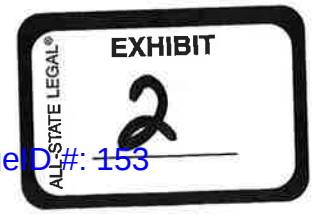
SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Consulting, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346



SavaSeniorCare Consulting, LLC
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328 Alexander Street, Suite 10
Marietta, GA, 30060

Tennessee HoldCo, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Administrative Services, LLC
Provider's/Health Plan's Address:	Address 1:
	Address 2:
	City: / State: / Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Administrative Services, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

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Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare Administrative Services, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

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☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: diagnostic films ☐ Other:	and studies

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5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To:
SavaSeniorCare Administrative Services,
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4
ALLSTATE LEGAL®

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☑ Addressee

B. Received by (Printed Name) | C. Date of Delivery 8-18-15

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

[signature]

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 2042

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 2042

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

MARIETTA, GA 30060

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00
Restricted Delivery Fee (Endorsement Required)	$0.00
	$0.00

0504 07

SavaSeniorCare Administrative Services, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

AUG 18 2015

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

ALL-STATE LEGAL®

AFFIDAVIT OF PERSON MAILING NOTICE

STATE OF ARKANSAS)
)
COUNTY OF MILLER)

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.

2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

   Exhibit 1, which is the notice letter.

   Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

   Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare, LLC to obtain complete medical records from each other provider being sent a notice.

   Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

   Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell
Trammell Piazza Law Firm, PLLC
TN BPR No. 21146
418 N. State Line Avenue
Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

Kelley Vasquez
NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 28, 2022
Miller County

TRAMMELL PIAZZA LAW FIRM PLLC

418 N. State Line Ave.
Texarkana, AR 71854
ph 870.779.1860
fx 870.779.1861
tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell
chad@trammellpiazza.com

Melody H. Piazza
Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

August 18, 2015

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

RE: Sarah Katherine Rodgers
Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

(A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.

B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.

(C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.

(D) A list of the name and address of all providers being sent this notice is attached to this notice.

(E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv
Enclosure

Provider List

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
731 Castle Heights Court
Lebanon, TN 37087

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
1 Ravinia Drive Suite 1500
Atlanta, GA 30346

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center
c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC
45 Broadway, Suite 520
New York, NY 10006

SMV Lebanon, LLC
c/o VCORP Services, LLC
15439 Old Hickory Blvd
Nashville, TN 37211

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SavaSeniorCare, LLC
c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC
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One Ravinia Drive, Suite 1500
Atlanta, GA 30346

SSC Submaster Holdings, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☒ All PHI in medical record ☒ Admission form ☒ Dictation reports ☒ Physician orders ☒ Intake/outtake ☒ Clinical Test ☒ Medication Sheets	All Dates Of Service	☒ Operative Information ☒ Cath lab ☒ Special test/therapy ☒ Rhythm Strips ☒ Nursing Information ☒ Transfer forms ☒ ER Information	All Dates Of Service	☒ Labor/delivery sum. ☒ OB nursing assess ☒ Postpartum flow sheet ☒ Itemized bill: ☒ UB-92: ☒ Other: diagnostic films ☐ Other:	and studies

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
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6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

EXHIBIT 3

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

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Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

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Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (*optional*):
Sarah Katherine Rodgers	5-15-26	415-30-9090

Provider's/Health Plan's Name:	Recipient's Name: SavaSeniorCare, LLC		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 7/1/16 Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

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I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LC (Initial) If not applicable, check here. ☐

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Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Caldwell	Date: 7-31-15
Print Name of Patient/Plan Member's Representative: Linda Caldwell	Relationship to Patient/Plan Member: Daughter

Revised 3/2003

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Trammell Piazza Law Firm, PLLC
418 North State Line Ave.
Texarkana, AR 71854

To: SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

PS Form **3817**, April 2007 PSN 7530-02-000-9065

U.S. POSTAGE
PAID
TEXARKANA, AR
71854
AUG 18, 15
AMOUNT
$1.35
R2305E125034-07

EXHIBIT
4

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SavaSeniorCare, LLC
One Ravinia Drive, Suite 1500
Atlanta, GA 30346

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) A. Holley | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 3500 0002 7817 2028

PS Form 3811, July 2013 Domestic Return Receipt

7011 3500 0002 7817 2028

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
OFFICIAL USE
ATLANTA, GA 30346

Postage	$ $3.45
Certified Fee	$2.80
Return Receipt Fee (Endorsement Required)	$0.00 $0.00
Restricted Delivery Fee (Endorsement Required)	$0.00 $0.00
Total Postage & Fees	$6.96

0504
07
Postmark Here
08/18/2015

Sent To SavaSeniorCare, LLC
Street, Apt. or PO Box One Ravinia Drive, Suite 1500
City, State Atlanta, GA 30346

PS Form 3800, August 2006 See Reverse for Instructions

EXHIBIT 5

EXHIBIT

"B"

IN THE CIRCUIT COURT OF TENNESSEE FOR THE
FIFTEENTH JUDICIAL DISTRICT AT LEBANON, WILSON COUNTY

Linda Caldwell, as Next of Kin of Sarah Katherine

Rodgers, Deceased, and on behalf of the wrongful
death beneficiaries of Sarah Katherine Rodgers Plaintiff,

v. Cause No. _____

Jury Demanded

SSC Lebanon Operating Company, LLC
d/b/a Lebanon Health and Rehabilitation Center;
SMV Lebanon, LLC; Sava SeniorCare, LLC;
Sava SeniorCare Administrative Services, LLC;
Sava SeniorCare Consulting, LLC; Tennessee HoldCo,
LLC; SSC Submaster Holdings, LLC Defendants.

CERTIFICATE OF GOOD FAITH

Medical malpractice case

PLAINTIFF'S FORM

A. In accordance with T.C.A. § 29-26-122, I hereby state the following: (Check item 1 or 2 below and sign your name beneath the item you have checked, verifying the information you have checked. Failure to check item 1 or 2 and/or not signing item 1 or 2 will make this case subject to dismissal with prejudice.)

☒ 1. The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:

(A) Are competent under § 29-26-115 to express opinion(s) in the case; and

(B) Believe, based on the information available from the medical records concerning the care and treatment of Jeanette Glasgow, deceased, for the incident(s) at issue, that there is a good faith basis to maintain the action consistent with the requirements of § 29-26-115.

Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

Or

☐ 2. The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:

(A) Are competent under § 29-26-115 to express opinion(s) in the case; and

(B) Believe, based on the information available from the medical records reviewed concerning the care and treatment of the Plaintiff for the incident(s) at issue, and as appropriate, information from the Plaintiff or others with knowledge of the incident(s) at issue, that there are facts material to the resolution of the case that cannot be reasonably ascertained from the medical records or information reasonably available to the Plaintiff or Plaintiff's counsel; and that despite the absence of this information there is a good faith basis for maintaining the action as to each Defendant consistent with the requirements of § 29-26-115. Refusal of the Defendant to release the medical records in a timely fashion, or where it is impossible for the Plaintiff to obtain the medical records shall waive the requirement that the expert review the medical records prior to expert certification.

Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

B. You MUST complete the information below and sign:

I have been found in violation of T.C.A. § 29-26-122 -0- prior times. (Insert number of prior violations by you.)

Signature of Person Executing this Document

11-24-15
Date